DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NETH	445502	A. BUILDING _____ B. WING _____	C 09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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F 000	INITIAL COMMENTS An investigation of complaint TN00054018, TN00054415, TN00054526, TN00054670, TN00054690, TN00055118, TN00055242, and TN00054244 was conducted on 9/14/2021 at The Waters Of Smyrna, LLC. No deficiencies were cited for complaint TN00054018, TN00054415, TN00054526, TN00054670, TN00054690, and TN00055118. Health deficiencies were cited in relation to complaint investigation TN00055242 and TN00055244, and unrelated health deficiencies were cited under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	F550 1. Resident # 8, 12, 13 were assessed by Director of Nursing. There were no adverse effects 2. The Director of Nursing and Certified Dietary Manager audited the resident meal schedule to ensure that all residents that are present in a shared room receive their meal tray at the same time. 3. CNT's and licensed nurses were in-serviced by the Administrator regarding the facility's Residents Rights policy, dignity -ensuring residents present in shared rooms receive their meals at the same time. 4. An audit will be conducted weekly x 4 weeks, weekly x 3 months and then randomly through observatory rounds to ensure the residents are treated with dignity and respect. This audit will be conducted by the Director of Nursing /designee, concerns will be addressed immediately. Findings will be discussed in the Quality Assurance meeting.	10-28-21
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE James Williford TITLE Administrator (X6) DATE 10-7-21

James Williford

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observations, and interview, the facility failed to treat 3 of 5 sampled residents (Resident #8, #12, and #13) with dignity as evidenced by their meals not being served at the same time as their roommates for 2 meal observations; supper meal on 8/31/2021 and lunch meal on 9/1/2021. The findings include: Review of the facility's policy dated 11/2016 titled, "Resident Rights Policy," revealed "...A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality..." Review of the medical record revealed Resident #7 was admitted to the facility on 12/6/2020 with	F 550		

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F 550	Continued From page 2 diagnoses which included Aphasia, Chronic Obstructive Pulmonary Disease, and Major Depression. Review of the Quarterly Minimum Data Set dated 8/24/2021 revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. Continued review revealed Resident #7 did not require assistance with meals. Review of the medical record revealed Resident #8 was admitted to the facility on 9/24/2018 with diagnoses which included Dementia Without Behavioral Disturbance and Dysphagia, Oropharyngeal Phase. Review of the quarterly MDS dated 8/25/2021 revealed Resident #8 had a BIMS score of 1 which indicated severe cognitive impairment. Continued review revealed Resident #8 required extensive assistance of staff for eating. Medical record review of the Visual/Bedside Kardex dated 9/24/2018 revealed Resident #8 required extensive assistance of staff for all meals. Review of the medical record revealed Resident #11 was admitted to the facility on 5/28/2021 with diagnoses which included Cerebral Vascular Disease and Aphasia. Review of the Quarterly MDS dated 6/1/2021 revealed Resident #11 required extensive assistance of staff for eating. Review of the medical record revealed Resident #12 was admitted to the facility on 6/19/2021 with	F 550		

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F 550	Continued From page 3 diagnoses which included Alcoholic Liver Disease and Pick's Disease. Review of the Annual MDS dated 6/11/2021 revealed Resident #12 required extensive assistance of staff with eating. Medical record review of Resident #12's comprehensive care plan revised on 3/18/2021, revealed the resident required extensive assistance of staff for eating. Review of the medical record revealed Resident #13 was admitted to the facility on 3/9/2015 with diagnoses which included Chronic Obstructive Pulmonary Disease, Alzheimer's Disease, and Anorexia. Review of the Quarterly MDS dated 7/9/2021 revealed Resident #13 required extensive assistance of staff for eating. Review of the medical record revealed Resident #14 was admitted to the facility on 1/28/2021 with diagnoses which included Cognitive Communication Deficit and Unspecified Protein-Calorie Malnutrition. Review of the Quarterly MDS dated 8/3/2021 revealed Resident #14 had a BIMS score of 3 which indicated severe cognitive impairment. Continued review revealed the resident required set up only for meals. Observation of the supper meal on 8/31/2021 at 6:20 PM revealed Certified Nurse Aide (CNA) #4 delivered a meal tray to the Resident #14. Observation of the supper meal on 8/31/2021 at	F 550		

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F 550	Continued From page 4 6:50 PM revealed CNA #3 delivered a meal tray to Resident #13 (roommate of Resident #14) after delivering meal trays to all the unassisted dinners. Observation of 200 hall on 8/31/2021 at 6:56 PM revealed staff were taking dining carts back to the kitchen after the supper meal. Continued observation of Room #203 revealed Resident #7 was sitting in her wheelchair with her supper tray sitting on her overbed table. Continued observation revealed Resident #8 lying in her bed with no supper tray on her overbed table. Resident #7 stated "I already ate, but she [pointing to her roommate, Resident #8] hasn't, they have to feed her." Observation of Room #203 on 8/31/2021 at 7:11 PM revealed staff were in sitting in a chair at the resident's bedside assisting Resident #8 with the evening supper meal. Observation of Room #307 on 9/1/2021 at 12:40 PM revealed Resident #11 (Bed A) was sitting up in his bed eating lunch. Continued observation revealed Resident #12 (Bed B) was lying in his bed with no lunch tray observed. Observation of the 300 hall on 9/1/2021 at 12:45 PM revealed a dining cart on the hall. Continued observation revealed Certified Nurse Aide CNA #1 opened the dining cart and stated [named]Resident #12's tray was still on the cart. Interview on 9/1/2021 at 12:50 PM with the Assistant Director of Nursing she stated, "dining trays come out on the halls and all trays are passed to the residents except for the assisted diners and they [assisted diners] are served last because they are assisted by staff, whether they	F 550		

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F 550	Continued From page 5 have a roommate or not." Continued interview she stated she expected both residents in the same room be served their trays at the same time. Interview on 9/1/2021 at 3:50 PM with Certified Nursing Assistant (CNA) #1 she stated, "the meal trays come out on the 400 hall first, then the 300 hall, then the 200 hall and the 100 hall is last; trays are passed to the independent diners first and the assisted diners are left on the carts until all independent diners are served." Continued interview CNA #1 confirmed Resident #11 already had his tray and was eating when she went to get Resident #12's tray to assist him. Continued interview CNA #1 confirmed Resident #11 and #12's lunch trays were not served at the same time.	F 550		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600	F600 1. Resident # 10 and 17 were assessed by the Director of Nursing/Social worker and referred to psych services to ensure no adverse effects occurred from the incident. The facility conducted a thorough investigation to include, interviews, skin assessments, employee suspension pending investigative outcome and reported the incident to the Department of Health.	10-28-21

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F 600	Continued From page 6 Based on facility policy review, medical record review, review of the facility investigations, and interviews, the facility failed to prevent verbal abuse for 2 of 18 sample residents (Resident #10 and 17). The findings include: Review of the facility's undated policy titled, "ABUSE PREVENTION PROGRAM," revealed, "...It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings...Staff members who are suspected of abuse or misconduct shall immediately be barred from duty, pending the outcome of the investigation, prosecution or disciplinary action against the employee...Verbal abuse: Any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend or disability..." Review of the facility's policy dated 11/2016 titled, "Resident Rights Policy," revealed "...A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality..." Review of the completed facility investigation dated 9/1/2021 for Resident #10 revealed the facility conducted skin assessments on residents with a low BIMS (Brief Interview of Mental Status)	F 600	2. The Director of Human Resources audited each employee file to ensure they have received training/in-service on the facility Abuse policy. 3. All facility staff were in-serviced by the Administrator regarding the facility Abuse policy. 4. An Abuse training audit will be conducted by the Administrator monthly X 3 months to ensure all new staff have been trained on the facility abuse policy. Concerns will be addressed immediately and findings will be discussed in the Quality Assurance meeting.	10-28-21

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F 600	Continued From page 7 score and performed resident interviews with residents who had a high BIMS score. Continued review revealed all staff were educated in Abuse and Abuse reporting. Continued review revealed GPN #1 was suspended pending investigation. Continued review revealed the incident was reported to the state agency. Review of the completed facility investigation dated 9/8/2021 for Resident #17 revealed the facility conducted skin assessments on residents with a low BIMS score and performed resident interviews with residents who had a high BIMS score. Continued review revealed all staff were educated in Abuse and Abuse reporting. Continued review revealed (agency) CNA #9 was listed as a 'do not return' to the facility. Continued review revealed the incident was reported to the state agency. Review of Graduate Practical Nurse (GPN) #1's employee file revealed she had no disciplinary actions on file. Continued review revealed he was not listed on the abuse registry and had recent abuse training on 9/1/2021. Review of CNA #9's employee file revealed he had no disciplinary actions against him. Continued review revealed he was not listed on the abuse registry and had recent abuse training dated 9/1/2021. Review of the medical record revealed Resident #10 was admitted to the facility on 3/18/2021 with diagnoses which included Vascular Dementia, Mood Disorder, and Major Depressive Disorder. Medical record review of a Quarterly Minimum Data Set (MDS) dated 8/2/2021 revealed	F 600		

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F 600	Continued From page 8 Resident #10 had a BIMS score of 8 which indicated moderate cognitive impairment. Continued review revealed the resident exhibited verbal behaviors 1-3 days of the 7 day look back period. Continued review required extensive assistance of staff with eating, dressing, and personal hygiene. Review of the medical record revealed Resident #17 was admitted to the facility on 8/23/2019 with diagnoses which included Cerebral Palsy, Major Depressive Disorder, Personal History of Urinary Tract Infections, and Congestive Heart Failure. Medical record review of the Quarterly MDS dated 7/7/2021 revealed Resident #17 had a BIMS score of 15 which indicated no cognitive impairment. Continued review revealed the resident was frequently incontinent and required extensive staff assistance with toileting. Review of the medical record revealed Resident #18 was admitted to the facility on 10/10/2019 with diagnoses which included Spastic Quadriplegic Cerebral Palsy, Anxiety, and Chronic Obstructive Pulmonary Disease. Medical record review of the Quarterly MDS dated 7/26/2021 revealed Resident #18 had a BIMS score of 15 which indicated no cognitive impairment. During an interview on 9/1/2021 at 11:53 AM, Certified Nursing Assistant (CNA) #2 stated she was changing Resident #10 and the resident always screamed out during care. Continued interview she stated, "someone came to his door and told him to 'stop that,' they had visitors in the building." During continued interview she stated	F 600		

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F 600	Continued From page 9 she did not tell the resident to 'stop that' and she didn't know who the staff was that came to the door and told the resident to stop that." During an interview on 9/1/2021 at 2:46 PM, GPN #1 stated she was assigned to the 100 hall this date and had been employed at the facility for 3 months. During continued interview she stated "[named] Resident #10's door was cracked open, and he was yelling at the aide while she was providing care for him; I went into the room and told the resident to "stop that" because we had visitors in the building." During an interview on 9/2/2021 at 3:15 PM, the Administrator stated "what [named] GPN #1 said to Resident #10 was inappropriate and poor judgement." He confirmed "an example of verbal abuse would be to tell a resident to shut up or to "stop that." During an interview on 9/14/2021 at 12:28 PM with Resident #17 she stated "about a month ago I needed to go to the bathroom; it was around lunch time, I was having trouble with my bladder and wet on myself. [named] Certified Nursing Assistant (CNA) #9 came into my room with an attitude and was rude to me and said, "Why didn't you call me to go to the bathroom." Continued interview she stated, "the 2nd time I had to go to the bathroom a few hours later, I wet on myself again and he [CNA #9] said "why did you do that, why didn't you call?" Continued interview she stated, "I was so mad I started crying and I told him he was being a "smart ass" and I reported it to [named] Nurse, he got close to my face and said 'sarcastically', I don't have to listen to what [named] Nurse said; then he started being nice to me." She stated, "he hasn't taken care of me	F 600		

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F 600	Continued From page 10 since." During an interview on 9/14/2021 at 4:18 PM the Director of Nursing confirmed she substantiated the allegations of verbal abuse for Residents #10 and #17 through resident and staff interviews. Continued interview she confirmed GPN #1 was suspended and would be terminated, and CNA #9 would not be able to return to the facility. During an interview on 9/14/2021 at 2:40 PM, Resident #18 stated when she called CNA #9 into the room to assist her with toileting her room mate also needed assistance with toileting and CNA #9 was rude and got in her roommates face and told her the nurse wasn't in charge of him and he didn't have to listen to her. During an interview on 9/14/2021 at 1:21 PM, Temporary Nurse Aide (TNA), stated Resident #17 told her an agency CNA refused to change her and refused to take her to the bathroom. During further interview she stated Resident #17 told her CNA #9 had got in her face and yelled at her and told her he wasn't going to change her. During further interview she stated Resident #18 was Resident #17's room mate and was in the room when Resident #17 told her about what happened and Resident #18 confirmed what Resident #17 had said did happen.	F 600		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804	F804 1. Resident # 12's was given a new tray at the appropriate temperature of at least 135 degrees Fahrenheit.	10-28-21

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F 804	Continued From page 11 §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, tray observation, and interview, the facility failed to provide food at a palatable and safe temperature for 1 tray delivery cart of 4 tray delivery carts during the noon meal on 9/1/2021. The findings include: Review of the facility's undated policy titled, "Monitoring Food Temperatures for Meal Service," revealed, " ...Food temperatures will be monitored daily to prevent food borne illness ...If hot foods are not 135 degrees Fahrenheit or higher when checked, they will be reheated to at least 135 degrees Fahrenheit. Cold foods and beverages which are not 41 degrees Fahrenheit or below will be chilled on ice or in the freezer ..." Review of the medical record revealed Resident #12 was admitted to the facility on 6/19/2021 with diagnoses which included Alcoholic Liver Disease and Pick's Disease. Review of the Annual MDS dated 6/11/2021 revealed Resident #12 required extensive assistance of staff with eating. Medical record review of Resident #12's comprehensive care plan revised on 3/18/2021 revealed the resident required extensive assistance of staff for eating. Observation of the 300 hall lunch meal service on	F 804	2. An audit was conducted of all food trays by the Dietary Manager to ensure each food tray had the appropriate temperature of at least 135 degrees Fahrenheit. 3. Facility nursing staff were in-serviced by the Director of Nursing regarding the timely distribution of meal trays to ensure meal trays are served at the appropriate temperature of at least 135 degrees Fahrenheit. 4. An audit will be conducted weekly x 4 weeks, weekly x 3 months and then randomly through observatory rounds to ensure the residents meal trays are served at the appropriate temperature are distributed timely. This audit will be conducted by the Director of Nursing /designee, concerns will be addressed immediately. Findings will be discussed in the Quality Assurance meeting.	

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THE WATERS OF SMYRNA, LLC	202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167

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F 804	Continued From page 12 9/1/2021 at 12:40 PM revealed residents were in their rooms eating lunch. Observation of the 300 hall meal service on 9/1/2021 at 12:45 PM revealed a dining tray delivery cart on the hall. Continued observation revealed Certified Nurse Aide (CNA) #1 opened the dining tray delivery cart and stated [named] Resident #12's tray was still on the cart. Observation and Interview on 9/1/2021 at 12:52 PM with the Dietary Manager revealed he opened the 300 hall dining tray delivery cart to perform food temperatures of Resident #12's meal tray. The Dietary Manager confirmed the lunch meal food temperatures of the dining meal tray were as follows: Pureed Mashed Potatoes were 105.5 degrees Fahrenheit, Pureed Cauliflower was 105.1 degrees Fahrenheit, Pureed Turkey was 94.5 degrees Fahrenheit, and the White Cake was 68.5 degrees Fahrenheit. Continued interview the Dietary manager confirmed, "the food temperatures should be 145 degrees or higher for hot foods and the cold foods are supposed to be less than 40 degrees." Continued interview he looked at his watch and stated, "this is the 300 hall cart and it has been out for an hour."	F 804		